TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Shahid H. Syed, M.D.

Respondent Name
American Interstate Insurance Company

MFDR Tracking Number
M4-11-0989

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 19, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The denial code and their description are too vague for our facility to determine the basis for the denial."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears the provider submitted the initial bill and reconsideration to AIG/Chartis. Therefore, Amerisafe has not had the opportunity to process the bill."

Response Submitted by: Amerisafe Risk Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2010	Treating Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §124.2, effective June 5, 2003, 28 TexReg 4285, sets out requirements for carrier reporting and notification.
2. 28 Texas Administrative Code §133.305, effective May 25, 2008, 33 TexReg 3954, sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 TexReg 3954, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §141.1, effective June 7, 1991, 16 TexReg 2876, sets out the procedures for requesting a benefit review conference.

5. Texas Labor Code §408.021, effective September 1, 1993, sets out provisions regarding entitlement to medical benefits.
6. Texas Labor Code §413.031, effective September 1, 2009, sets out provisions regarding medical dispute resolution.
7. The services in dispute were reduced or denied by the respondent with the following reason codes:
   - A1 – Claim/Service denied.
   - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Are there unresolved issues of compensability, extent of injury, or liability regarding the services in dispute?
2. Can the Division adjudicate the medical fee issues in this dispute?

Findings

1. Submitted documentation finds that the disputed services were denied with claim adjustment code A1 – "Claim/Service denied." 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury."

   28 Texas Administrative Code §133.305(b) requires that:

   > If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

   28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, "the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals."

   The appropriate dispute process for unresolved issues of compensability, extent of injury, or liability requires the health care provider to submit a request for a benefit review conference pursuant to 28 Texas Administrative Code §141.1. All outstanding issues regarding compensability, extent of injury, or liability for the disputed services must be resolved before requesting medical fee dispute resolution.

   Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury, or liability for the same service(s) for which there is a medical fee dispute. No documentation was presented to support that the issue(s) of compensability, extent of injury, or liability have been resolved.

2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the outstanding issues concerning compensability, extent of injury, or liability for the injured employee's workers' compensation claim with respect to the disputed medical services have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 before submitting a request for medical fee dispute resolution regarding the same services. Consequently, medical fee dispute resolution staff has no authority to consider the disputed fee issues or to order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	February 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.